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UNITED STATES OF AMERICA

BEFORE THE NATIONAL LABOR RELATIONS BOARD

REGION 20

OLEANDERS HOLDINGS, LLC D/B/A SACRAMENTO SUB-ACUTE,)		
Employer,)	Case	20-RC-074337
and.)		
)		
SEIU UNITED HEALTHCARE WORKERS)		
WORKERS WEST CTW, CLC,)		
Union -Petitioner.)		
Omon -r cutioner.)		

EMPLOYER'S REQUEST FOR REVIEW

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I. PRELIMINARY STATEMENT AND SUMMARY OF ARGUMENT

Pursuant to Section 102.67 of the Board's Rules and Regulations, Oleanders Holdings, LLC, d/ba/ Sacramento Sub-Acute (hereinafter "Sacramento Sub-Acute" or "Employer") seeks review of the Decision and Direction of Election (hereinafter "Decision") issued by Regional Director Joseph Frankl on March 7, 2012, ordering an *Armour-Globe* self-determination election for the Respiratory Therapists -- *conceded technical employees* -- to vote on whether they wished to be included in a service and maintenance unit represented by SEIU-UHW (hereinafter "Union").¹ Review is required because in his decision the Regional Director (1) departed from established Board precedent in concluding that a "substantial" community of interest existed between the Respiratory Therapists and the service and maintenance employees and (2) made clearly erroneous factual findings to support his conclusion.²

Stated simply, the Respiratory Therapists (hereinafter "RTs") do not share a "community of interest" with the service and maintenance employees, no less a "substantial" community of interest as found by the Regional Director, and indeed, the Board, in the health care industry, does not normally include technical employees in a service and maintenance unit. The plain truth is that the only "commonalities" between the two disparate employee groups is that they work, to a very limited extent, in the same facility and care, also to a very limited extent, for the same patients — two factors that are common to all employees who work at Sacramento Sub-Acute and which factors, by themselves, do not meet the Board's "community

The issue of whether the Board has a legal quorum such that it can entertain this Request is presently in litigation. In filing this Request, the Employer does not concede that a legal quorum exists and reserves the right to have its Request reviewed by a legally constituted Board in the event that it is determined that the Board lacks a quorum.

² A hearing was held on February 23, 2012 in Sacramento, California, and "Tr." refers to the hearing transcript followed by a page reference. "EX" refers to the Employer's Exhibits introduced at the hearing.

of interest" standard.

In rendering his decision, the Regional Director failed to apply the Board's eight factor test. Moreover, the Regional Director created out of whole cloth one of the most significant facts -- the existence of shared supervision -- in order to support his faulty conclusion and ignored contrary evidence that undercut his factual underpinnings. The Regional Director was not free to change the record evidence to support his legal conclusion.

II. STATEMENT OF FACTS³

The Employer operates a single-story 96-bed skilled nursing, sub-acute nursing, and rehabilitative care facility in Sacramento, California that provides both short and long-term care to patients. The layout of the facility is like an "E," comprised of a main corridor with a hallway at each end.

Patient rooms are situated along both the main corridor and hallways. Some rooms have multiple beds. Fifty-four beds are designated for residents requiring skilled nursing care and 42 beds are for residents requiring sub-acute care. Skilled nursing care rooms are situated from the middle of the main corridor to the end of a hallway (skilled side), and sub-acute nursing care rooms are situated from the middle of the main corridor in the other direction to the end of the hallway (sub-acute side). A nursing station is at each end of the main corridor.

The facility also includes a main patient dining room, a second dining area for patients, a common employee break room, a therapy room, a kitchen, a laundry area, storage areas, an RT office and break area, and a medical records office.

Skilled nursing care residents come to the Employer primarily from private homes and

This Statement of Facts is taken directly from the Regional Director's Decision. (Decision pp. 2-13.) Any additional facts are indicated by an appropriate reference to the hearing transcript. The more important facts that the Regional Director distorted or ignored are set forth in the Argument section of this Brief with appropriate transcript references.

hospitals and comprise what is viewed as a typical "nursing home" population. Sub-acute care residents require a higher level of care than skilled nursing care patients and are usually on ventilators or have tracheotomy tubes to assist them in breathing. Most sub-acute patients come to the Employer from hospitals or long-term care facilities.

The Employer provides patients with 24-hour a day, seven-day a week nursing and respiratory therapy care along, where necessary, assistance with eating, bathing and toileting; physical, occupational and/or speech therapy; recreational activities; and social services. The Employer is legally required to provide skilled nursing care patients with a daily average of 3.2 hours of nursing care (by RNs, LVNs, or CNAs) and sub-acute patients with a daily average of 5.8 hours of nursing care. The care provided by RTs is *not* counted in meeting these legal requirements.

The facility is under the overall supervision of administrator David Terry. The facility has various departments, including nursing (RNs, LVNs and CNAs), housekeeping (housekeepers, laundry employees and janitors), dietary (cooks and dietary aides), and rehabilitative (speech, occupational and physical therapists). *The RTs are in their own department*.

Each department's employees have a direct supervisor who oversees and schedules them and who reports to the facility administrator. The housekeeping supervisor supervises housekeepers, laundry employees, and janitors; the dietary supervisor supervises the cooks and dietary aides; and the medical records director supervises the medical records employee. The central supply clerk reports directly to Terry, the facility administrator. The director of rehabilitation supervises the speech, occupational and physical therapists

RNs, LVNs and CNAs working on the "skilled nursing" side are directly supervised by the Director of Nursing ("DON"), and on the night shift are overseen by a charge nurse. On the sub-acute side, RNs, LVNs, and CNAs are supervised by the Clinical Manager, Holly Everts, who reports to the DON. Everts also directly supervises the RTs, and *with respect to that supervision*, she reports to the facility administrator, *not the Director of Nurses*. (Tr.: 50-51, 154-156, 160, 172, 174.). Both the DON and Everts work on the day shift.

Sacramento Sub-Acute has approximately 198 full-time, part-time, and "on-call" employees. (Tr.: 29-30; EX 3.)⁴ Of these employees approximately 80 are covered by a Collective Bargaining Agreement (CNAs, RNAs, cooks, dietary aides, housekeepers, janitors, one medical records assistant, and one central supply clerk). Employees who are not part of the recognized unit include RNs, LVNs, speech, occupational and physical therapists, activities employees, social services employees, and business office employees; as well as the approximately 15 RTs at issue herein.

RNs and LVNs provide 24/7 nursing care to patients. They can be assigned to either the subacute or skilled side on different shifts but do not work on both sides during the same shift. RNs and LVNs are also capable of providing respiratory care, but on the sub-acute side, RTs have primary responsibility for such care.

The job of the CNAs is to ensure that patients are comfortable and that their physical needs are met. They provide 24/7 care, involving the positioning and repositioning of patients; they get patients out of bed, and assist them with feeding, bathing and toileting. They also deliver and pick up meal trays and laundry from resident rooms. The CNAs work on three shifts and the number of CNAs is highest during the day and evening shifts and lowest during the night shift.

CNAs also do daily charting of patients' activities and the physical care provided to them.

⁴ Relying on testimony, the Regional Director incorrectly found that the facility had 163 employees. (Decision, p. 6.) However, the documentary evidence clearly demonstrates that the number of employees was much larger -- 198 employees. (Tr.: 29-30; EX 3.) Thus, the 80 union represented employees do not comprise even half the work force.

RNs, LVNs, CNAs and RTs chart the condition of patients in their care and the RNs, LVNs, and RTs also chart medications administered to patients. Rehabilitative Nursing Assistants (RNAs) have the same training and certification as CNAs, but instead of providing daily assistance in feeding, bathing and toileting to residents as do the CNAs, RNAs assist patients in maintaining their level of physical functioning. Unlike CNAs, RNAs only work day shifts and do not provide 24/7 coverage.

Cooks and dietary aides prepare meals for patients and on rare occasions deliver and pick up meal trays from resident rooms. They also clean up the kitchen and do dishwashing. Laundry employees do laundering for the facility and sometimes distribute and pick up linens from resident rooms. Housekeeping employees clean the facility; janitors clean and also perform floor maintenance and minor repair work. The central supply clerk orders and stocks supplies for the facility. The medical records employee works in the medical records office and assists the medical records director in maintaining patients' files and requesting medical records from hospitals and other entities

CNAs, RNAs, housekeepers and the janitors work throughout the facility. Cooks and dietary aides work mainly in the kitchen but on occasion take food trays to and from patient rooms and the dining areas. They seldom enter the rooms of sub-acute patients, many of whom are fed through gastrostomy tubes. Similarly, the central supply clerk and medical records assistant spend little or no time in patient care areas.

Laundry employees work primarily in the laundry area, but on rare occasions take linens to and from patient rooms. Other employees not covered by the Collective Bargaining Agreement also work throughout the facility, including RNs and LVNs. PTs, OTs and speech therapists perform their work in patient rooms, in common areas, or in the therapy room.

The Employer has no educational requirements for most of the employees covered by the

Collective Bargaining Agreement. CNAs and RNAs are the only employees covered by the Collective Bargaining Agreement who are required to have a high school diploma or GED. CNAs and RNAs must complete an eight-week course of training to be certified as a nursing assistant.

With regard to the educational requirements of employees not covered by the Collective Bargaining Agreement, RNs are required to pass a two-year course of training in nursing, and be certified and licensed; LVNs are also required to undergo training in nursing and be certified and licensed.

The only employees who are required to provide 24/7 coverage for patients are RNs, LVNs, CNAs and RTs. RNs, LVNs and CNAs work seven and a half or eight-hour shifts. RTs work 12-hour shifts and are the only employees who do so.

Housekeeping and janitorial employees work eight hour shifts covering the hours from about 5 or 6 a.m. to 10 p.m., and dietary employees work eight hour shifts covering the hours from 5 to 6 a.m. until about 8 p.m. Most other employees work typical eight-hour day shifts.

All employees are hourly paid and those covered by the Collective Bargaining Agreement have pay rates between \$12.32 and \$17.49 an hour with RNAs being the highest paid employees. In comparison, RTs are paid between \$25 and \$40 an hour.

Employees covered by the Collective Bargaining Agreement receive similar benefits. RTs and other employees not covered by the Collective Bargaining Agreement receive the same medical, dental and vision care benefits as do employees covered by the Collective Bargaining Agreement. Non-covered employees may participate in the same 401 (k) plan and receive the same sick leave benefits as employees covered by the Collective Bargaining Agreement, except that they do not receive the attendance bonus provided for in the contract. Employees not covered by the Collective Bargaining Agreement also receive all but one of the same holidays.

All employees and supervisors, as well as Administrator Terry, attend monthly staff

meetings. Departmental meetings are also held regularly, including separate departmental meetings attended only by RTs,

The Employer employs about 15 RTs, two assigned to each 12-hour shift. RTs are the only employees who work 12-hour shifts, from 6 a.m. to 6:30 p.m. and from 6 p.m. to 6:30 a.m. They are in a separate department and are not considered part of the nursing department. RTs are primarily assigned to work with sub-acute care patients who are on ventilators, but at times they also work with skilled nursing care patients. They spend most of their work time in patients' rooms and they make regular rounds every two hours. Their responsibilities include monitoring patients with regard to respiratory issues; giving breathing treatments to patients; responding to emergencies to resuscitate patients; and charting.

RTs are directly supervised by Clinician Manager Holly Everts, an RN, who reports directly to Administrator Terry with regard to the RTs. Everts also supervises the RNs, LVNs, and CNAs who work on the sub-acute side, and with regard to them, she reports to the DON, who in turn reports to Terry. The DON directly supervises the RNs, LVNs, and CNAs working on the skilled side of the Employer's facility. *Everts has no responsibility for nursing staff (RNs, LVNs and CNAs) working on the skilled side*.

RNs, LVNs, CNAs and RTs working on the night shift also report to a charge nurse, and the RTs also call Everts at home if a respiratory issue arises during the night shift. The Employer employs both RRTs (registered respiratory therapists) and CRTs (certified respiratory therapists). RRTs must have a high school degree or GED; successfully complete a two-year course of study at a college or technical school; receive a certificate and degree; complete an internship; and are licensed by the State. CRTs are required to undergo additional testing in order to receive the designation of certified respiratory therapist but otherwise have the same requirements as RRTs.

Most of the RTs' work time is spent caring for sub-acute residents who are on ventilators (vents). They are primarily responsible for taking care of the airway-based needs of such patients and patients who have tracheotomy tubes (trachs) to assist them in breathing. Each of the two RTs on a shift is responsible for a maximum of ten residents on vents. RNs and/or LVNs provide care to additional residents if there are more than ten residents on vents. At the time of the hearing, there were 12 residents on vents and each RT was assigned to six such residents on a shift. RTs monitor residents on vents to ensure vent tubing is properly connected and the settings are correct. RTs also respond to vent alarms and emergencies.

RTs use equipment to suction the throats of residents who have trach tubes to keep their airways clear. RTs also perform breathing treatments on patients, such as putting a percussion vest on a resident that shakes the resident's chest to loosen congestion in the airways and lungs.

III. ARGUMENT

A. THE APPLICABLE COMMUNITY OF INTEREST STANDARD.

The Union seeks to have the RTs at Sacramento Sub-Acute vote on whether they wish to join the Union's existing service and maintenance unit. For such an *Armour-Globe's* election to be ordered, the two groups of employees must share a community of interest. "...[T]he Board has held that a self-determination election is the proper method by which an incumbent union...may add unrepresented employees to an existing unit, if the employees sought to be included share a community of interest with unit employees and 'constitute an identifiable, distinct segment as to constitute an appropriate voting group." *St. Vincent Charity Medical Center*, 357 NLRB No. 79 (2011) citing *Warner-Lambert Co.*, 298 NLRB 993, 995 (1990); and *see also Unisys Corporation*, 354 NLRB No. 92 (2009).

As recently reiterated in Specialty Healthcare, 357 NLRB No. 83, slip op. p. 9 (2011), in

⁵ Armour-Globe refers to the Board's two seminal cases: *The Globe Machine and Stamping Co.*, 3 NLRB 294 (1937) and Armour and Company, 40 NLRB 1333 (1942).

determining whether a community of interest exists between two groups of employees, the Board looks at the following *eight* factors:

- 1. Whether the employees are organized into separate departments (conformance with the employer's organizational structure);
 - 2. Similarity of skills and training;
 - 3. Similarity of job functions and job overlap;
 - 4. Functional integration;
 - 5. Frequency of contact;
 - 6. Frequency of interchange;
 - 7. Similarity of terms and conditions of employment; and
 - 8. Level of shared supervision.

While the Regional Director's Decision pays "lip service" to the Board's test, in order to support his erroneous conclusion, the Regional Director truncates the Board's test into four factors (skills and function, supervision, interchange, working conditions) and then chooses to also consider bargaining history and the extent of organization. (Decision p. 13.) In addition, the Regional Director distorts the factual record to conclude that RTs *frequently* assist CNAs in the performance of CNA duties and that the RTs have *frequent* daily contact "not only with the CNAs but also with employees in several other [unit] classifications" -- when the evidence is flatly to the contrary. (Decision, p. 14) Indeed, when analyzed, this *supposed* "frequent" contact is what underlies the Regional Director's entire conclusion.

In contrast, when the Board's eight factor test is actually analyzed and applied, the *record facts* clearly demonstrate that the RTs have little in common with the service and maintenance employees, and RTs definitely do not share a community of interest with the employees in the existing bargaining unit.

1. The Employer's Organizational Structure.

Under the Employer's administrative structure, the RTs constitute a separate department. None of the bargaining unit employees are part of the respiratory department. While the RTs are a recognizable, distinct group, they are not part of the department or departments which contain the bargaining unit employees. Thus, the Employer's organizational structure fails to demonstrate the existence of any community of interest between these two employee groups.

2. Similarity of Skills and Training.

Clearly, there are vast and significant differences in the education, training, and skills of the RTs when compared to the education, training, and skills of the bargaining unit employees. The RTs have two years of post high school education and must pass a licensing test administered by the State of California (and in the case of certified RTs, a second test). In contrast, except for the CNAs/RNAs, the employees in the existing bargaining unit are not even required to have a high school diploma or its equivalency. While the CNAs/RNAs are required to be high school graduates, they become certified as nursing assistants by simply taking one additional course. In addition, unlike the bargaining unit employees, the RTs have legally mandated continuing education requirements that they must complete every two years in order to remain licensed. (Tr.: 217.)

The actual skills displayed by the two groups are also vastly different. RTs are trained in monitoring ventilators, suctioning, administering medical therapies, keeping patients' airways open, and responding to medical emergencies.⁶ They are part of a *medical* team and routinely consult with the patients' physicians about the care of the patients entrusted to them.

Bargaining unit employees have none of these skills. The CNAs/RNAs assist the patients

⁶ In comparison, when a ventilator alarm goes off, all the CNA can do is call for assistance. (Tr.: 150.)

in their daily *living* activities - resting comfortably, eating, bathing, and going to the toilet. They do not ensure that patients' airways remain open; they do not administer medicine; they do *not* provide medical treatment of any kind; and they do not consult with the patients' physicians. CNAs have no medical training or medical skills. They are not part of the patients' medical treatment team.

In addition, no argument of any kind can be made that the other bargaining unit employees - dietary, cooks, laundry, housekeeping, janitors, central supply clerks, or medical records assistant - share any of the skills displayed by the RTs. These bargaining unit employees do not even provide *direct* patient care and are certainly not involved in the patients' medical treatment.

3. Similarity of Job Functions and Job Overlap.

Because these two groups of employees have dissimilar skills, it follows that there is no similarity in their job functions nor any job overlap. The RTs primary job function is provide airway based medical care to the patients in the facility's subacute beds. None of the unit employees provide any sort of medical care, no less airway based care. The CNAs primary job function is to to assist the patients in performing normal life activities. The housekeeping and janitors primary function is to clean the facility or the patients' room. The dietary workers primary function is to prepare meals for the patients, clean the kitchen area, and wash the dirty dishes and cooking utensils. The laundry workers primary job function is to clean the patients' linens.

Nor is there any job overlap between the two groups of employees. There was not a scintilla of evidence that any dietary/cook, laundry, or housekeeping employee or any CNA/RNA ever performed any respiratory function of any kind or performed any part of the RTs' job duties. Indeed, no such overlap could occur inasmuch as *it would be illegal* for these bargaining unit employees to perform any part of the RTs' job. (Tr.: 58.) Conversely, there was

also no evidence that any RT performed any other type bargaining unit work; i.e., cooking a meal, cleaning up, or washing bed linens.

Notwithstanding this evidentiary record, the Regional Director found that RTs "frequently assist" CNAs in the performance of their duties. (Decision, p. 14.) Yet the only such evidence was that RTs *infrequently* assist CNAs in repositioning or bathing patients. (Tr.: 181-183.) In making the contrary evidentiary finding, the Regional Director ignored the relevant evidence and gave overriding importance to this "assistance factor", when, in fact, it was trivial and legally meaningless.

First, and most importantly, these interactions are not unique to the RTs and the CNAs. The CNAs *do not rely* on the RTs for this assistance. The CNAs will seek repositioning assistance from anyone whom is present. Tracy Davis, an RT, testified⁷:

"It is my experience that the CNAs get whoever they can [to assist in the repositioning]." (Tr.: 181.)

Davis' testimony is consistent with other testimony that the facility requires CNA to obtain assistance in repositioning trach patients and "everyone" assists the CNA, including the facility administrator. (Tr.: 151-152, 167, 172.) Similarly, the RTs are *not* the primary source of bathing assistance. CNAs first ask for assistance from the nursing staff - LVNs and RNs - who also have the ability to disconnect the ventilators and place the patients on portable oxygen. (Tr.: 151, 167-168, 208-209.)

The fact that everyone assists in repositioning patients and RNs and LVNs assist in

⁷ The Regional Director's entire conclusion is based on Davis' *direct* testimony. Not only does the Regional Director ignore other testimony but he chooses to ignore the significant manner in which cross-examination qualified Davis' testimony. For example, although Davis made it appear that she frequently worked on the skilled nursing side, cross examination demonstrated that she actually spent less than 6% of her time on the skilled side and that her working colleague spent no time on the skilled nursing side. (See discussion *infra*, *p*. 19)

bathing patients means that the identical assistance provided by the RTs to the CNAs *is not* unique to these two groups such that a community of interest is established. The same type of interaction occurs between the bargaining unit employees and other facility employees.

Second, the extent of the RTs' involvement in these "assistive" activities is *minimal*. With respect to repositioning patients in their bed, *at best, this RT assistance occurs less than five times a day during the RTs 12 hour shift. - hardly a significant overlap in job function given that these patients must be repositioned every three or four hours. (<i>Tr.: 205.*) Indeed, there would be a total of 35 repositionings of one RT's patients on one RT shift, yet the RT would only assist with 4 of these 35 repositioning -- trivial at best.⁸

With respect to bathing a patient, the record also indicates that the amount of RT assistance is *minimal* and dwarfed by what other employees do. Here, again, Davis' testimony is telling. In her four months at the facility, Davis assisted in bathing patients approximately 24 times - not even close to once a shift. (Tr.: 225.) Moreover, as a practical matter, it is obvious that the RTs working the night shift *never* assist the CNAs with bathing a patient because bathing occurs *during the day* when the patients are awake. Here, again, the Regional Director has changed the record evidence to find "frequent" conduct when it is highly infrequent.

⁸ The number comes directly from Davis' testimony. According to Davis, each trach patient must be repositioned every three or four hours. (Tr.: 205) So, on a 12 hour RT shift, a particular trach patient would be repositioned an average of 3.5 times. Because a RT normally has 10 patients, there would be a total of 35 repositioning of RT patients during an RT's shift. According to Davis, she would assist "less than five times during her shift". *Id.* Clearly, others were involved in the repositioning on a much larger scale.

⁹ It makes perfect sense that RTs would not normally assist in the bathing of patients. Davis testified that it took from 15 to 30 minutes to bath a patient. (Tr. 210.) Thus, an RT who assisted the CNA would be off the floor for this entire period of time forcing the other RT to cover her patients - hardly a safe situation on a routine basis. Given the larger number of RNs and LVNs on duty, it makes much more sense for the nurses to assist the CNAs in bathing the trach patients.

In sum, the Regional Director's conclusion that such assistance was frequent is not supported by the record. The plain truth is that such assistance was infrequent at best and, at that, was limited to a very few CNAs working on the subacute side of the facility. (See discussion *infra* pp. 19-21.) The Regional Director has changed the record evidence to support his conclusion.

Nor does the Regional Director point to any evidence of RTs performing the job functions of housekeeping, laundry, janitorial or dietary employees. In fact, Davis testified that the night shift RTs have *no contact whatsoever* with housekeeping employees. (Tr.: 216-217.) Even more significantly, Davis testified that neither the day shift nor night shift RTs have any contact with laundry or dietary employees. (Tr.: 188, 216-217.) Indeed, cooks, dietary employees, and laundry workers have no work reason for being in patients' room where they would interact with an RT. (Tr.: 133.) In other words, *half the RT work force - those night shift* RTs - never interact in any way with these bargaining unit employees. Clearly, there can be no job overlap if the employees are not even present at the same time.

4. Functional Integration.

Taking care of patients is team effort. All the departments and all the employees in the facility must coordinate in order to properly care for the patients entrusted to their care. (Tr.: 190-192.) Patients need all of the services offered by all of the facility's employees. (Tr.: 193.)

The RTs are part of the medical team and are part of the facility's functional integration. But, what is legally significant in terms of analyzing the RTs' community of interest with the bargaining unit employees is whether there is anything "special" or "unique" about the functional integration between the bargaining unit employees and the RTs. The evidence shows that there is not, and if anything, the CNAs have a greater functional integration with the RNs and LVNs.

The simple fact is that caring for patients, by definition, requires coordination. There is

nothing special or unique about the functional integration between the RTs and the bargaining unit employees. If anything, there is less integration between the RTs and the bargaining unit employees, because as noted, during the day the RTs have no contact whatsoever with laundry or dietary employees and, at night, no contact with laundry, dietary, or housekeeping employees. Accordingly, there is no unique functional integration between the RTs and the bargaining unit employees to support a conclusion that the two groups share a community of interest.

5. Frequency of Contact.

While there is some contact between the RTs and the CNAs, here again, the contact is not great when compared to the numbers involved nor is it special or unique to the relationship between the RTs and the bargaining unit employees. Moreover, as repeatedly noted, there is no contact between the RTs and the dietary or laundry employees, and limited contact between the housekeepers and the RTs inasmuch as the night shift RTs (half the workforce) has no interactions with the housekeepers.

Nonetheless, the Regional Director finds that the RTs have "frequent daily contact" with *other unit employee* classifications -- although for good reasons, he does not spell out the nature of that contact. (Decision, p. 14.) Moreover, in order to support his conclusion, he erroneously concludes that RTs spend a "portion" of their time working on the skilled nursing side. (Decision p. 11.) Significantly, the Regional Director *fails* to specify exactly what that portion of time is because the evidence clearly showed that it was trivial at best. In other words, most RTs would never interact with the bargaining unit employees working on the skilled nursing side of the facility. Here, again, a detailed analysis of the facts proves the point.

For the vast, vast majority of their time, the RTs work is confined to the sub-acute side of the facility. (Tr.: 38-39.) The RTs will only perform work in the skilled nursing area when (1) a sub-acute patient no longer qualifies for such treatment but still has a "trach" and is

transferred to the skilled nursing side of the facility; or (2) when a patient with a trach is admitted directly onto the skilled nursing unit. *Id.* (Tr.: 111.) In both cases, the amount of time that the RT is required to spend on the skilled nursing side is trivial.

Davis, the witness that the Regional Director relied on for the contrary conclusion showed -- on cross examination -- the true extent of RT work on the skilled nursing side. During her three most recent shifts, Davis worked on the skilled side *only once and then only for 20 minutes*. (Tr.: 195-196.) Expanding out to her last 18 shifts, Davis testified that she worked a total of 14 hours on the skilled side, which would equate *to 6% of her work hours* during those 18 twelve hour shifts. (Tr.: 197.)

As Davis conceded, there are currently only 2 or 3 "trach" patients on the skilled side and they only require the services of an RT *once a month for a total of 15 minutes*. (Tr.: 177-179, 201-202.) Moreover, although Davis would have to "cover" for any RT colleague who went over to the skilled side, *she testified that she had no knowledge of whether her RT colleague performed work on the skilled side*. (Tr.: 201.)

According to Davis, RTs only spend additional time on the skilled side if there are patients there who must be routinely "rounded" - every two hours - or if they are called for an emergency (which Davis testified had only happened to her on an average of *once a month*). (Tr.: 177-178, 180, 203.) Thus, while the RTs do on occasion perform work on the skilled side, it is minimal and trivial at best.

Notwithstanding this testimony, the Regional Director concludes that the RTs *routinely* work on the skilled nursing side and interact with bargaining unit employees on that side. The truth is to the contrary. Most RTs perform no work on the skilled nursing side and what work they do perform is trivial in time. Further analysis conclusively demonstrates the point.

There are a total of 58 CNAs. (EX 3.) On the subacute side of the facility, the day shift

would have approximately 4 CNAs on duty while the swing and NOC shifts would have 3 CNAs on duty. (Tr. 99.) However, because the RTs only work half the beds on the subacute side, the extent of their contacts with these 4 or 3 CNAs would depend on the CNAs' patient assignments. Because the RTs would rarely go over to the skilled nursing side of the facility, the RTs would have virtually no contact with the approximately 5 CNAs on the skilled nursing side during the day or the 4 CNAs working the swing shift, or the 3 CNAs working the NOC shift. (Tr.: 99.)

Moreover, the use of the word "interactions" is in itself misleading. For example, while there would be up to 4 CNAs on the day shift with whom the RTs might have contact, the CNAs also have patient assignments, and they would be with their assigned patients caring out their assigned tasks. So, the dealings or contacts would occur throughout the day on a sporadic basis when the CNA happens to be in the same patient room as the RT.

In addition, there are a total of 5 housekeepers and one janitor. (EX 3.) Here, again, during their day shift, at most the RTs would have contact with one housekeeper and one janitor. The day RTs, but not the night RTs, might also have sporadic contact with the Central Supply Clerk and the Medical Records Assistant but such contact would be fleeting in character given the job responsibilities of these two unit employees.

When analyzed, it is obvious that the contact between *a handful of bargaining unit employees and the RTs* is neither constant nor comprehensive, nor even frequent. Contact between some of the bargaining unit employees and the RTs occurs because that is the very nature of patient care. But, it is not unique to the relationship between the RTs and the bargaining unit employees. Moreover, because the RTs generally work only on the subacute side, their contact is much less than would occur between the bargaining unit employees and the other therapists, or the LVNs, or the RNs. These other non-represented employees would not

only have much greater contact with the CNAs but would also have contact with the laundry and dietary workers with whom the RTs have no contact.

6. Frequency of Interchange.

Simply stated, there is no interchange, whether permanent or temporary, between the employees in the RT classification and employees working in the bargaining unit classifications -- a point conceded by the Regional Director in his Decision. (Decision p. 12.)

7. Similarity of Terms and Conditions of Employment.

The RT wage rate is much, much higher than the wage scale applicable to the bargaining unit employees. That difference alone demonstrates the lack of a community of interest between the two employee groups. Employees making \$25 to \$40 per hour are unlikely to have the same economic and work concerns as employees averaging \$15 per hour.

Except for an additional holiday, an attendance bonus, and possible some other minor differences (as mandated by the collective bargaining agreement), the benefit package that both sets of employees receive is the same. (Tr.: 100-105.) But, this is legally irrelevant where one benefit package is *offered to all employees working in the facility*; in other words, the benefit package is not specific to just the RTs and the bargaining unit employees.

The Board does not give much weight to common terms and conditions of employment in its community of interest analysis if those terms and conditions are shared by employee groups other than the two at issue. *See Hilander Foods*, 348 NLRB 1200 (2006); *Laboratory Corporation of America Holdings*, 341 NLRB 1079 (2004); and *Stormont-Vail Healthcare*, 340 NLRB 1205 (2003). Thus, the fact that all these employees have the same basic benefit package becomes irrelevant. Notwithstanding this Board precedent, the Regional Director relied on this legally irrelevant factor to justify his conclusion. (Decision p. 14.)

In stark contrast, however, are the differences in the two groups working environment and

conditions. Differences that demonstrate that a community of interest is lacking, but *which the*Regional Director chose to ignore in his Decision.

- 1. Bargaining unit employees punch a time clock. RTs do not. (Tr.: 161.)
- 2. Bargaining unit employees work 8 hour shifts. RTs work 12 hour shifts. (Tr.: 50, 61-63, 98-99, 188, 216-117.)
- 3. Bargaining unit employees work as assigned. *RTs divide their patient workload by mutual agreement*. (Tr.: 146, 148, 166, 184, 199-200, 217-218.)
- 4. RTs have an assigned office where they take their breaks. Bargaining unit employees do not have an office and take their breaks in the general employee break room. (Tr.: 51-52, 83, 211-212, 228.)
- 5. Meetings are held with just RTs present to discuss both clinical issues, and more significantly, *work issues such as hours and pay*. (Tr.: 156-157, 170, 218.) Separate meetings are held for the CNAs which RTs do not attend. (Tr.: 54.)
- 6. RTs discuss patient care with the patients' physicians and are involved in making medical decisions. Bargaining unit employees do not consult with physicians and play no role in determining the patients' medical treatment. (Tr.: 82-83, 153, 217-218, 230-231.)
 - 7. RTs have their own bulletin board. (Tr.: 212.)
- 8. For the vast majority of their time, the RTs work is limited to 20 rooms on the subacute side of the facility. The bargaining unit employees work throughout the facility. (Tr.: 38-39, 41-44, 111, 133.)
- 9. RTs have continuing education requirements which they must satisfy to remain licensed. (Tr.: 217.)
- 10. The Clinical Manager schedules the RTs. The staffer schedules the CNAs; the Housekeeping Supervisor schedules the housekeepers, janitors, and laundry workers; and the

Dietary Manager schedules the dietary employees. (Tr.: 82-83.)

In contrast, the Regional Director points to no "similarities" between the RTs and the bargaining unit employees that are specific or unique to those two groups of employees. Nothing joins these two groups of employees together and distinguishes them from the other employees the facility.

8. Level of Shared Supervision.

The RTs direct supervisor is the Clinical Manager, who with respect to the RTs' supervision, then reports to the facility Administrator. At night, the RTs' nominal supervisor is the Charge Nurse. The Clinical Manager also supervises the RNs, LVNs, and CNAs working on the subacute side of the facility, but only while they are working on that side of the facility. With respect to that supervision, the Clinical Manager reports to the Director of Nursing. Except to the extent that the Clinical Manager supervises the CNAs, the CNAs are supervised by the DON.

To the extent that there is any "shared" supervision between the RTs and the bargaining unit, this minimal overlap constitutes the shared supervision. It is clearly minimal because while the Clinical Manager has supervisory authority over the subacute CNAs, that authority only exists when they are actually working in the subacute area. In other words, she is responsible for supervising *the 4 CNAs* who are assigned to work in the subacute area during the day.

Significantly, however, in supervising the subacute CNAs, the Clinical Manager reports to the DON and not the facility Administrator, as she does with respect to the RTs. Moreover, as was the case with the other factors, this "shared" supervision is also shared with other employees who the Union does not seek to include. The Clinical Manager also supervises the RNs and the LVNs working in the subacute area so *there is no unique community of interest* established between the RTs and the bargaining unit employees through this one shared

supervisory link.

In addition, there is no evidence concerning the extent to which the Clinical Manager does anything more than supervise the CNAs work to ensure that it meets the patients' needs and complies with the Employer's practice. For instance, unlike the RTs, the Clinical Manager does not set the CNAs schedule; that is done by the staffer. Nor is there any evidence that the Clinical Manager issues written warnings or suspensions to the CNAs, grants leave requests, is involved in their hiring or firing, or performs any other meaningful, higher level supervisory oversight. See, e.g., Hilander Foods, supra, 348 NLRB at 1203 ("...the Board puts emphasis on whether the employees perform their day-to-day work under the supervision of one who is involved in rating their performance and in affecting their job status and who is personally involved with the daily matter which make up their grievances and routine problems.")

Just as significantly, there is no overlap in supervision between the RTs and any other bargaining unit employees. The housekeepers, janitors, and laundry workers are supervised by the Housekeeping Supervisor; the dietary workers and cooks are supervised by the Dietary Manager; the medical records assistant is supervised by the Medical Records Supervisor; and the Central Supply Clerk is directly supervised by the facility Administrator.

Finally, the fact that the supervisory pyramid at the facility ends up with the facility Administrator is not sufficient to establish "shared" supervision under the Board's community of interest standard. *See McLean Hosp. Corp.*, 309 NLRB 564, 575 (1992) (citing *Omni International Hotel*, 283 NLRB 475 (1987) (petitioned-for unit of maintenance employees appropriate where they have separate immediate supervision, notwithstanding the fact that they are jointly supervised at a higher level with other employees).

Faced with these unequivocal facts, the Regional Director created his own facts to support his conclusion of "shared supervision". (Decision p. 15.) The Regional Director

"finds" that the RTs report to the DON. (Decision p. 6.)¹⁰ *This is a flat out misstatement of the record.* The evidence clearly demonstrated that the DON exercises *no supervisory authority over the RTs*. (Tr.: 50-51, 154-156, 160, 172, 174.) The Regional Director had made up this fact for one simple reason: he is fully aware that without common supervision his conclusion of a shared community of interest falls -- as it necessarily does when the actual evidence is considered.

B. THE COMMUNITY OF INTEREST STANDARD IS NOT MET.

As the foregoing analysis of the Board's community of interest test demonstrates, the RTs do not share a community of interest with the service and maintenance employees. Indeed, under applicable Board law such a conclusion should be expected even in the absence of such an analysis. Technical employees have higher skill levels and educational training when compared to service and maintenance workers resulting in different working conditions. In fact, the *Board has long recognized that RTs are technical employees*, not service and maintenance employees and should not normally be combined. *E.g., Children's Hospital of Pittsburgh*, 222 NLRB 588, 593 (1976).

Moreover, the Board codified its view when it promulgated its Health Care Rule and established, for acute care hospitals, 8 appropriate bargaining units, one of which was a technical employees unit encompassing RTs while a separate unit was established for service and maintenance employees. (29 CFR Section 103.30 (1990).)¹¹ See Women and Infants' Hospital of Rhode Island, 333 NLRB 479 (2001). Thus, the Board has recognized that in general RTs lack a

¹⁰ In the words of the Regional Director: "As discussed more fully below, Everts also directly supervises RTs on the sub-acute side and RTs also report to the DON on the day shift...." (Decision p. 6.)

¹¹ The Board has declined to apply its Health Care Rule to skilled nursing facilities. *E.g.*, *Specialty Healthcare*, *supra*. However, the Board has never stated whether its Health Care Rule is applicable to a subacute facility. That issue need not be addressed now because the Union does not seek a separate unit of RTs.

community of interest with service and maintenance employees. *Compare Aspirus Grand View*, Decision and Order Granting Unit Clarification, Case 30-UC-431 (2010) (granting union's request to include the newly established position of Respiratory Therapy *Assistant* in a unit of service and maintenance employees).

Ultimately, the Regional Director's conclusion comes down to the fact that the RTs and the bargaining unit employees are caring for some of the same patients and in the course of providing that "integrated" care, the two groups of employees have some limited interactions. While research disclosed no Board case directly addressing this argument in the context of patient care, the Board long ago rejected the analogous argument in the manufacturing industry. *Continental Baking Co.*, 99 NLRB 777, 784 (1952) (working on the same products is not sufficient to establish a distinct community of interest). There is no greater logic to accepting the argument when it comes to patient care.

Indeed, accepting the Regional Director's conclusion would essentially eviscerate the community of interest standard in hospitals, nursing homes, and subacute facilities. Healthcare facilities are in the business of providing integrated care. A cafeteria worker in a hospital or nursing home is just as essential for the well-being of the patient as the nurse who provides medical care. Every one in a health care facility provides some sort of direct or indirect patient care. That is the nature of healthcare. And the obvious result of such integrated care is that employees interact with each other and, from time to time, assist each other. That is all that is occurring at Sacramento Sub-Acute between the RTs and some, but far from all, of the bargaining unit employees. By itself, this integrated care model is not sufficient to establish a community of interest between the RTs and the service and maintenance employees.

Every one of Board's community of interest factors mitigates against a finding that there is a community of interest between the RTs and the service and maintenance employees. The

Regional Director's contrary conclusion is based on record "facts" that do not exist.

Moreover, to the extent that any of the "community of interest" factors exist with

respect to the RTs and the bargaining unit members, those factors are not unique to those two

groups but exist with respect to all, or most of the other, unrepresented employees in the facility.

There is nothing special or unique that binds the RTs and the bargaining unit members together.

Quite to the contrary, as the preceding analysis demonstrates, there are many more differences,

and significant differences at that, then there are similarities between the two employee groups.

While under Specialty Healthcare, supra, the Union might be entitled to an election to represent

the RTs in a separate bargaining unit, the Union is not entitled to join the RTs to its existing

service and maintenance unit.

IV. CONCLUSION

Accordingly, inasmuch as the record evidence fails to establish a community of interest

between the RTs and the bargaining unit members, review should be granted and the Regional

Director's Decision should be reversed and the representation petition should be dismissed.

Dated: March 19, 2012

Respectfully Submitted,

S/_____

Law Office of Henry F. Telfeian

By: Henry F. Telfeian Attorney For Employer

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CERTIFICATE OF SERVICE

This is to certify that on this date I have served a true and correct copy of EMPLOYER'S REQUEST FOR REVIEW in Case No. 20-RC-074337 via electronic filing through the National Labor Relations Board's website, www.NLRB.gov, upon:

Joseph F. Frankl Regional Director, Region 20 National Labor Relations Board 901 Market Street, Suite 400 San Francisco, CA 94103-1738

EMPLOYER'S REQUEST FOR REVIEW was also served, via electronic mail, upon counsel of record for the Petitioner, as follows:

Manuel A. Boigues, Esq. Weinberg, Roger & Rosenfeld 1001 Marina Village Parkway, Suite 200 Alameda, CA 94501-1091 mboigues@unioncounsel.net

This 19th day of March 2012.

s/ Henry F. Telfeian

Law Office of Henry F. Telfeian 1247 Alvarado Road Berkeley, CA 94705